

**OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)**

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: **Biktarvy®** (bictegravir, emtricitabine, and tenofovir alafenamide)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limit = 30 tablets/30 days

DIAGNOSIS AND MEDICAL INFORMATION: To receive a **ONE Year approval** for Biktarvy®, all of the following questions **MUST** be answered to qualify or authorization process will be delayed.

1. Does member have a diagnosis of HIV? Yes No
AND
2. Is member 18 years or older? Yes No
AND
3. Member will be tested for Hepatitis-B infection prior to initiation of therapy. Yes No
AND
4. Does member have a creatinine clearance (CrCl) \geq 30 mL/min within the last 30 days? Yes No
AND
5. Member does **NOT** have moderate to severe hepatic impairment. Yes No
AND
6. Member is **NOT** on other antiretroviral treatment (ART) medications. Yes No
AND
7. Member is **NOT** on concurrent dofetilide or rifampin. Yes No

(continued on next page; Signature **MUST** be included with this request)

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Medication being provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*REVISED/UPDATED: 6/18/2018;n 8/16/2018